Filed 8/23/19 Charkhchian v. Logisticare Solutions, LLC CA2/5

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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FIVE

SHOOCHANIK CHARKHCHIAN, Plaintiff and Appellant, v. LOGISTICARE SOLUTIONS, LLC, Defendant and Respondent.	B289896 (Los Angeles County Super. Ct. No. BC663223)

APPEAL from a judgment of the Superior Court of the County of Los Angeles. Richard E. Rico, Judge. Reversed.

Law Offices of Armen M. Tashjian, Armen M. Tashjian, for Plaintiff and Appellant.

Cozen O'Connor, Alexander M. Kargher and David A. Shimkin, for Defendant and Respondent.

I. INTRODUCTION

Plaintiff Shoochanik Charkhchian (plaintiff) sued defendant Logisticare Solutions, LLC (defendant) for wrongful death and negligence, alleging that defendant breached its duty of care to plaintiff's daughter (the decedent) by failing to timely transport her to life-sustaining hemodialysis treatments. The trial court sustained defendant's demurrer to the wrongful death and negligence claims without leave to amend, ruling that those claims were time-barred under Code of Civil Procedure section 340.5 (section 340.5)—the statute of limitations for professional negligence claims against health care providers.

On appeal, plaintiff argues, among other things, that the trial court erred because the allegations in her complaint did not show as a matter of law that defendant was a "health care provider" as that term is defined and construed under section 340.5. Plaintiff also contends that the alternative grounds advanced in support of the demurrer concerning insufficient allegations of breach of duty and causation were also without merit.

Because we cannot determine, from the face of the complaint, that defendant was a licensed or certified health care provider subject to the limitations period in section 340.5, we hold that the trial court erred by applying that section to bar plaintiff's wrongful death and negligence claims. We also conclude that the alternative grounds for affirmance advanced by defendant are without merit. We therefore reverse the judgment.

II. FACTUAL AND PROCEDURAL BACKGROUND

A. *First Amended Complaint*

On May 30, 2017, plaintiff filed her original complaint against Blue Cross of California (Blue Cross) and defendant. On August 17, 2017, plaintiff filed the operative first amended complaint, alleging the following against defendant:

The decedent had renal disease that required her to receive life-sustaining hemodialysis treatments three times a week. Blue Cross, as the decedent's health care service plan, agreed to provide nonemergency transportation to and from the decedent's hemodialysis treatments. Blue Cross, in turn, contracted with defendant to provide the decedent with nonemergency, "non-ambulance type" transportation to and from the decedent's medically necessary treatments. Based on its agreement with Blue Cross, defendant assumed a duty of care to ensure that the required treatment-related transportation was timely provided to the decedent.

On October 23, 2015, plaintiff telephoned Blue Cross and requested authorization for transportation of the decedent to and from her hemodialysis appointments in November 2015. Blue Cross informed plaintiff that the requested transportation for the decedent during November 2015 was authorized.

On November 7, 2015, plaintiff telephoned defendant and requested transportation to and from the decedent's hemodialysis treatments. Defendant told plaintiff that it could not provide the requested transportation because there was no authorization from Blue Cross on file.

Without the necessary transportation, the decedent was unable to obtain the required treatment for her renal condition, causing it to worsen. On November 9, 2015, plaintiff again called Blue Cross and was informed—contrary to Blue Cross's previous assurance that the treatment-related transportation was authorized—that "there was no authorization on file for any transportation."

Due to the continued lack of transportation to and from her hemodialysis treatments, the decedent's renal condition worsened. On November 11, 2015, plaintiff telephoned Blue Cross a third time and was informed that the authorization for the "necessary transportation" was on file. That necessary transportation, however, was never provided to the decedent and, on November 13, 2015, she passed away.

In the first cause of action against defendant for wrongful death, plaintiff alleged that defendant's failure to provide the requested transportation services for the decedent caused her death. In the third cause of action against defendant for negligence, plaintiff alleged that defendant owed the decedent a "duty of care to act reasonably in [discharging its] obligations, including . . . properly processing [and ensuring that] the requisite authorization for non-emergency or non-ambulance type transportation [by defendant] was on file, and to [ensure] the authorizations were received and processed [so that the decedent's] hemodialysis treatments were not affected or delayed due to lack of transportation and or authorization." Plaintiff further alleged that defendant's breach of that duty "resulted in

. . . [a] fatal delay of life saving hemodialysis treatment" for the decedent.[1]

B. *Defendant's Demurrer*

On September 12, 2017, defendant filed a demurrer to the first amended complaint, arguing that the one-year limitation period in section 340.5 applied to time-bar plaintiff's wrongful death and negligence causes of action because those claims were based on allegations of "professional negligence" as that term is defined in section 340.5. Defendant did not, however, expressly assert, much less affirmatively demonstrate, that it was a health care provider as that term is defined in section 340.5.[2] On September 20, 2017, plaintiff opposed the demurrer, arguing that defendant was not a health care provider engaged in rendering professional medical services. On September 27, 2017, defendant filed its reply claiming, among other things, that it was a health care provider, citing Health and Safety Code section 1367.11, but without explaining how that section relates to the licensure

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[1] Plaintiff also asserted a fourth cause of action against defendant for violation of Penal Code section 632.7. According to plaintiff, defendant intentionally recorded its telephone calls with the decedent and plaintiff without their knowledge or permission in violation of that statute, entitling plaintiff to civil penalties of $5,000 for each call recorded.

[2] For example, defendant made no attempt to request judicial notice of documents showing that it was a licensed or certified health care provider for purposes of section 340.5.

requirements of section 340.5.[3] In the alternative, defendant claimed it was a "'legal representative'" of a licensed health care provider, i.e., Blue Cross, under section 340.5.

C. *Trial Court's Ruling*

On January 31, 2018, the trial court held a hearing on the demurrer. After considering the oral arguments of the parties, the trial court sustained the demurrer to the first and third causes of action without leave to amend.[4] The trial court's ruling discussed, among other cases, the holdings in *Flores v. Presbyterian Intercommunity Hospital* (2016) 63 Cal.4th 75 (*Flores*) and the subsequent Court of Appeal decision in *Nava v. Saddleback Memorial Medical Center* (2016) 4 Cal.App.5th 285 (*Nava*), defining and distinguishing between claims for professional and ordinary negligence, but did not address the

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[3] Health and Safety Code section 1367.11 provides in pertinent part: "(a) Every health care service plan issued, amended, or renewed on or after January 1, 1987, that offers coverage for medical transportation services, shall contain a provision providing for direct reimbursement to any provider of covered medical transportation services if the provider has not received payment for those services from any other source. [¶] (b) Subdivision (a) shall not apply to any transaction between a provider of medical transportation services and a health care service plan if the parties have entered into a contract providing for direct payment." Although defendant cited that section in the trial court, it does not rely on that authority on appeal.

[4] The trial court also overruled the demurrer to the fourth cause of action against defendant for violation of Penal Code section 632.7.

separate issue of whether defendant qualified as a health care provider under section 340.5. The trial court sustained the demurrer on the grounds that plaintiff's wrongful death and negligence claims were barred by the statute of limitations.

D. *Dismissals*

On March 1, 2018, plaintiff filed a voluntary request for dismissal of the remaining fourth cause of action against defendant for violation of Penal Code section 632.7. On March 9, 2018, the clerk entered a dismissal of plaintiff's fourth cause of action only. Approximately one month later, on April 11 and 13, 2018, the trial court entered identical judgments of dismissal in favor of defendant.

E. *Notice of Appeal*

On May 7, 2018, plaintiff filed a notice of appeal from the trial court's April 11, 2018, judgment of dismissal.

III. DISCUSSION

A. *Timeliness of Appeal*

Defendant initially asserts that plaintiff's appeal must be dismissed as untimely. According to defendant, after the trial court entered its order sustaining the demurrer to the first and third causes of action, plaintiff filed on March 1, 2018, a request for dismissal of the fourth cause of action—her only remaining claim against defendant—which request defendant characterizes

as an appealable final judgment, citing *Kurwa v. Kislinger* (2013) 57 Cal.4th 1097, 1106. Because plaintiff did not file her notice of appeal until May 7, 2018, defendant maintains that the appeal was untimely because it was filed over 60 days from the service of the request for dismissal on March 1, 2018. (See Cal. Rules of Court, rule 8.104(a)(1)(B).)

Under California Rules of Court, rule 8.104(a)(1), a notice of appeal is timely if filed on or before 180 days after entry of judgment; however, if the superior court clerk or a party serves a document entitled "Notice of Entry" of judgment or "a filed-endorsed copy of the judgment" (showing date of service or accompanied by proof of service), the notice of appeal must be filed within 60 days after service. "Judgment" includes an appealable order. (Cal. Rules of Court, rule 8.104(e).)

Even assuming, without deciding, that the dismissal of plaintiff's fourth cause of action constituted the final judgment from which the appeal must have been taken, defendant's timeliness contention fails for two independent reasons. First, the time to appeal runs from the date of the entry of the appealable judgment or order. (Cal. Rules of Court, rule 8.104(c)(1).) Although plaintiff filed and served her request for dismissal on March 1, 2018, the clerk did not enter the dismissal itself until March 9, 2018. Thus, even if we assume that the clerk's filed-stamped dismissal was served the same date—triggering the 60-day period within which to appeal—plaintiff timely filed her notice of appeal 59 days thereafter on May 7, 2018. (Cal. Rules of Court, rule 8.104(a)(1)(B).)

Second, our record does not reflect that a filed-stamped copy of the clerk's *dismissal* was ever served by either the clerk or one of the parties. Instead, the record shows only that

plaintiff's March 1, 2018, *request* for dismissal was served by plaintiff on defendant. Because it is the *entry of the dismissal*, not the filing of the request, that constitutes the appealable judgment, only the service of a filed-stamped copy of that executed dismissal could have triggered the 60-day period for filing the appeal. (Cal. Rules of Court, rule 8.104(a)(1)(B).) Here, because there is no indication in our record that the filed-stamped copy of the dismissal was ever served, plaintiff had 180 days from its entry by the clerk to file her appeal. (Cal. Rules of Court, rule 8.104(a)(1)(C).)[5] Plaintiff's appeal is timely.

B. *Ruling on Demurrer*

According to plaintiff, her complaint does not contain allegations showing that defendant is a "health care provider" or that her action is one for "professional negligence" as those terms are defined in section 340.5. Instead, as plaintiff construes her allegations, defendant is merely a broker of transportation services, not a health care provider, and her claims for wrongful death and negligence are based on allegations of ordinary negligence against that "broker," not on allegations of professional negligence. Thus, plaintiff concludes that the trial court erred by applying the one-year limitations period in section 340.5 to her wrongful death and negligence claims, which

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[5] The record on appeal also includes two judgments, dated April 11, 2018, and April 13, 2018. But again, there is no indication that these judgments were served on a party. Moreover, although the record includes a "Notice of Entry of Judgment," that document bears neither a filed stamp nor proof of service.

plaintiff maintains are subject to, and timely under, the two-year limitations period in Code of Civil Procedure section 335.1.

1. Standard of Review

"In reviewing the sufficiency of a complaint against a general demurrer, we are guided by long-settled rules. 'We treat the demurrer as admitting all material facts properly pleaded, but not contentions, deductions or conclusions of fact or law. [Citation.] We also consider matters which may be judicially noticed.' (*Serrano v. Priest* (1971) 5 Cal.3d 584, 591 . . . .) Further, we give the complaint a reasonable interpretation, reading it as a whole and its parts in their context. (*Speegle v. Board of Fire Underwriters* (1946) 29 Cal.2d 34, 42 . . . .) When a demurrer is sustained, we determine whether the complaint states facts sufficient to constitute a cause of action. (See *Hill v. Miller* (1966) 64 Cal.2d 757, 759 . . . .) And when it is sustained without leave to amend, we decide whether there is a reasonable possibility that the defect can be cured by amendment: if it can be, the trial court has abused its discretion and we reverse; if not, there has been no abuse of discretion and we affirm. (*Kilgore v. Younger* (1982) 30 Cal.3d 770, 781 . . . ; *Cooper v. Leslie Salt Co.* (1969) 70 Cal.2d 627, 636 . . . .) The burden of proving such reasonable possibility is squarely on the plaintiff. (*Cooper v. Leslie Salt Co., supra*, [70 Cal.2d] at p. 636.)" (*Blank v. Kirwan* (1985) 39 Cal.3d 311, 318.)

2. Statute of Limitations

"Unlike most other personal injury actions, professional negligence actions against health care providers must be brought within 'three years after the date of injury or one year after the plaintiff discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.' ([section 340.5].)" (*Flores, supra*, 63 Cal.4th at p. 79.) "Thus, section 340.5 applies to any complaint that satisfies these three requirements: (1) the action must be 'against a health care provider,' for (2) 'injury or death,' based on (3) the health care provider's 'alleged professional negligence.'" (*Preferred Risk Mutual Ins. Co. v. Reiswig* (1999) 21 Cal.4th 208, 220.)

A defendant has the burden of pleading and proving that a claim is unenforceable because it is barred by the statute of limitations. (*Walton v. City of Red Bluff* (1991) 2 Cal.App.4th 117, 131 ["where a claim is unenforceable the burden is on the defense to demonstrate unenforceability. When a claim is barred by the statute of limitations the issue must be pleaded as an affirmative defense"].) Thus, at the pleading stage, it was not incumbent on plaintiff to anticipate the limitations issue or plead facts relevant to that defense. Instead, defendant, as the demurring party, had the burden of demonstrating that it was a licensed or certified health care provider under section 340.5.

We agree with plaintiff that the allegations of the complaint do not establish, as a matter of law, that defendant is a health care provider as that term is defined in section 340.5. Section 340.5 provides, in pertinent part: "For the purposes of this section: [¶] (1) 'Health care provider' means any person licensed or certified pursuant to Division 2 (commencing with

Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. 'Health care provider' includes the legal representatives of a health care provider."

The operative complaint does not state or imply that defendant was licensed or certified under the provisions of either Division 2 of the Business and Professions Code or Division 2 of the Health and Safety Code. Nor does it state facts from which we could conclude that defendant was exempt from such licensure or certification. (See, e.g., *Chosak v. Alameda County Medical* Center (2007) 153 Cal.App.4th 549, 555 ["the term 'health care provider,' as . . . defined [in section 340.5], includes a medical student lawfully practicing medicine under a[n] . . . exemption to . . . licensing requirements"].) Instead, the complaint merely alleges that defendant contracted with Blue Cross to provide transportation services for the benefit of the decedent. Those transportation services are alleged to be medically necessary, but there is nothing further from which to infer that the services were to be provided pursuant to a required license or certificate. Nor did defendant make any attempt to request judicial notice of documents showing that it was a licensed or certified health care provider for purposes of section 340.5.

Absent some factual basis in support of defendant's conclusion that it was a licensed or certified health care provider entitled to the protections of section 340.5, we cannot conclude as

a matter of law that plaintiff's wrongful death and negligence claims are barred under the one-year limitations period in that section.

Defendant nonetheless contends that "[c]ourts have consistently applied the provisions of MICRA and section 340.[5], to medical transportation providers because they come within the expansive definition of health care provider." None of the cases cited by defendant supports its position. In *Nava, supra,* 4 Cal.App.5th 285, for instance, a plaintiff was injured while "being transported in the hospital on a gurney" (*id.* at p. 287), and sued the hospital and an ambulance company. The court considered the issue of whether plaintiff's lawsuit alleged negligence that occurred "in the rendering of professional services" as that term is defined in section 340.5, subdivision (1). (*Id.* at pp. 290-293.) But it did not consider whether the ambulance company was a "health care provider" as defined in section 340.5, subdivision (1). ""'It is axiomatic that language in a judicial opinion is to be understood in accordance with the facts and issues before the court. An opinion is not authority for propositions not considered.'" [Citation.] "An appellate decision is not authority for everything said in the court's opinion but only 'for the points actually involved and actually decided.'" [Citation.]' (*People v. Knoller* (2007) 41 Cal.4th 139, 154-155 . . . .)" (*Areso v. CarMax, Inc.* (2011) 195 Cal.App.4th 996, 1005-1006.)

In *Belton v. Bowers Ambulance Serv.* (1999) 20 Cal.4th 928, 930 (*Belton*), the Supreme Court applied the provisions of MICRA to an action against an ambulance company brought by an inmate injured while being transported from the prison to a hospital. But, as the Court of Appeal later explained, "[i]n *Belton*, neither party disputed that the defendant ambulance

company was a health care provider within the meaning of MICRA. The court itself felt no need to address whether the transportation of a prisoner to a hospital by an ambulance fell within MICRA and held that the one-year limitations period of . . . section 340.5 would bar the action unless some other provision extended the time." (*Canister v. Emergency Ambulance Service, Inc.* (2008) 160 Cal.App.4th 388, 403 (*Canister*).) Thus, *Belton* does not support the proposition that any medical transportation provider falls within the definition of "health care provider" provided in section 340.5.

Finally, in *Canister, supra,* 160 Cal.App.4th 388, the court applied the definition of health care provider in section 340.5 to emergency medical technicians (EMTs), even though the revised statutory scheme under which they were currently licensed, Division 2.5 of the Health and Safety, section 1797, et seq., was no longer part of Division 2 of that code. (*Id.* at p. 392 [pursuant to Health and Safety Code section 1797.4, licensed EMTs continue to meet the definition of "health care providers," even though the statute under which they are licensed is no longer part of Division 2 of the Health and Safety Code].) Moreover, the court in that case noted that the ambulance company that employed the EMTs was also subject to the protections of section 340.5, because that company was sued solely under a respondeat superior theory. "Under the respondeat superior doctrine, MICRA applies to an employing entity held vicariously liable for the professional negligence of its agents, *if such agents are health care providers*. (*Lathrop v. HealthCare Partners Medical Group* (2004) 114 Cal.App.4th 1412, 1424 . . . .) When the liability of an employer in a medical malpractice action is wholly derivative and not based on fault, the vicariously liable employer is entitled to

invoke against the injured plaintiff whatever limitations on liability are available to its *health care provider employee*. (*Id.* at pp. 1425-1426.)" (*Canister, supra,* 160 Cal.App.4th at p. 395, fn. 4, italics added; see also *Aldana v. Stillwagon* (2016) 2 Cal.App.5th 1, 5 [recognizing that a paramedic supervisor fell within the definition of a health care provider under section 340.5, but concluding that, under the facts of that case, the supervisor was not providing professional medical services, but rather was acting as a driver of a motor vehicle who owed a general duty of care to members of the public].)

Defendant concedes that the pleadings in the complaint do not expressly allege that it is either licensed or certified as required by section 340.5, but it argues that because the complaint is "silent" on this issue, we must assume that it was licensed or certified to provide the medically necessary transportation services that it contractually agreed to provide. Under the governing standard of review, however, only properly pleaded facts are deemed admitted, and we must "give the complaint a reasonable interpretation," not one that assumes material facts that were not pleaded. Here, as explained, there are no facts pleaded that would support a reasonable inference that defendant or its employees were licensed, certified, or exempt under specific sections of either the Business and Professions or the Health and Safety Codes.

Defendant also argues that it must be considered a health care provider because plaintiff's theory of liability is "wholly derivative . . . of [the decedent's] physician." According to defendant, only a physician can authorize the medically necessary transportation that the decedent required, citing specifically to Title 22 of the Code of Regulations sections 51003

and 51323, subdivision (b)(2) ["All nonemergency medical transportation, necessary to obtain program covered services, requires a physician's, dentist's or podiatrist's prescription and prior authorization . . ."]. But those regulations govern medical benefits provided to recipients of Medicaid/Medi-Cal, and defendant offers no explanation of how those regulations apply under the facts pleaded in the operative complaint. (See Cal. Code Regs., tit. 22, § 51003, subd. (a) ["'Prior authorization,' or 'authorization' means authorization granted by a designated Medi-Cal consultant or by a Primary Care Case Management (PCCM) plan and is obtained through submission and approval of a (treatment authorization request)"].) Indeed, the complaint does not state or imply that the decedent was a recipient of such benefits, and instead alleges that the decedent was entitled to the transportation services pursuant to her health care service plan agreement with Blue Cross. In addition, although the complaint references "authorization" to transport the decedent, there is nothing to suggest that such referenced authorization was from a treating physician pursuant to the cited regulations, as opposed to authorization from Blue Cross itself based on the terms of the health care service plan agreement at issue and Blue Cross's separate agreement with defendant. Because this argument is premised on matters beyond the four corners of the operative complaint, it cannot and does not alter our conclusion that defendant failed to satisfy its burden on demurrer of showing that it was a health care provider as a matter of law.

C. *Alternative Grounds for Sustaining Demurrer*

Although the trial court limited its ruling on the demurrer to the statute of limitations issue, defendant argues that the complaint was also deficient because it failed to properly plead that defendant breached its duty to plaintiff and that defendant's breach of duty was a proximate cause of the decedent's death. According to defendant, plaintiff admitted that defendant was not authorized to transport the decedent between November 7 and 11, 2015, and, absent such authorization to transport, defendant could not have breached any duty to transport during that time; and because defendant either was not authorized to transport the decedent, or plaintiff failed to timely request such transport, defendant could not have been a substantial factor in the decedent's death.

Defendant's breach of duty contention is based on an unreasonable interpretation of the operative complaint. Fairly read, the complaint does not admit that defendant lacked authorization to transport the decedent. Instead, the complaint states that plaintiff received inconsistent information from Blue Cross and defendant on the authorization issue. Moreover, the complaint unequivocally alleges that both Blue Cross—through its health care plan agreement with plaintiff—and defendant—through its contract with Blue Cross—had a duty to decedent to provide medically necessary transportation. In light of that allegation, the subsequent allegations concerning the inconsistent information that plaintiff received from either Blue Cross or defendant simply assert alternative theories of liability: either Blue Cross breached its duty to inform defendant that it was authorized to provide the requested transportation; or

defendant breached its duty to transport the decedent because Blue Cross had timely informed defendant of the authorization to provide the transportation, but defendant negligently failed to do so. Thus, under the latter theory, plaintiff adequately pleaded breach of duty.

Defendant's related causation argument is equally flawed. According to defendant, if it was not authorized to transport the decedent between November 7 and 11, 2015, its failure to transport her during that time could not have been a substantial factor in her death; and, because plaintiff did not ask defendant to transport the decedent after November 11, 2015, its failure to do so between that date and her November 13 death could not have played any role in her demise. Instead, according to defendant, it was plaintiff's failure to request transportation of the decedent during the days just prior to her death, or to call 911, that caused the decedent's death.

This argument ignores the allegations showing that defendant had a duty to transport the decedent to her medically necessary treatments during November 2015, and that, for whatever reason, defendant failed to provide that necessary transportation. That alleged failure to transport as required therefore adequately pleaded that the negligence of either defendant or Blue Cross was a substantial factor in the decedent's death, or that the negligence of both of them was such a factor.

V. DISPOSITION

The judgment is reversed. Plaintiff is awarded costs on appeal.

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KIM, J.

We concur:

BAKER, Acting P. J.

MOOR, J.